

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009343

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2682**

STATE FILE NUMBER

**FILED MAR 14 1963**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>8 yr 2 mo</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Mo. b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Masonic Home of Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>4130 a Ashland Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <b>Adele</b> Middle <b>Schlegel</b> Last <b>Schlegel</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1963</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/1885</b>		9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Henry Tollæ</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Newmann</b>				14. NAME OF HUSBAND OR WIFE <b>George W. Schlegel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Masonic Home of Mo. Carl J. Stein</b> <b>5351 Delmar Blvd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Influenza</b> DUE TO (c) <b>481x</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <b>1/8/55</b> to <b>3/5/63</b> and last saw her <b>3/5/63</b> Death occurred at <b>6:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>Harold E. Walters M.D.</b> (Degree or title)						22b. ADDRESS <b>3720 Washington St</b>			22c. DATE SIGNED <b>3-5-63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 8, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frieden's Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		(State)			
24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 Natural Bridge Bl.</b> ADDRESS						25. DATE RECD. BY LOCAL REG. <b>MAR 7 1963</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>			

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

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Rev. 4/59

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## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Robert E. Muhleman

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.